Welcome to Coventry Health Care of Nebraska, Inc.

In order to assist you and your dependents in transitioning care to Coventry in-network providers, **please complete the following form**. A case manager may be in contact with you to assist in the transition of care.

Group Name: _____ **Effective Date:** _____

Employee Name:_____

Social Security Number: _____ **Date of Birth:** _____

Phone Numbers – Work: _____ **Home:** _____ **Can we contact you at work?** _____

DO YOU OR ANY OF YOUR DEPENDENTS RECEIVE ANY OF THE FOLLOWING?

Services	Services/Equipment Receiving	Member Name	Provider Name and Phone Number
Home Health			
Durable Medical Equipment			
IV Fluids and Medication at home			
Self Administered Injections			

PLEASE LIST ANY PENDING SURGICAL PROCEDURES

Procedure	Date Scheduled	Member Name	Provider Name and Phone Number

PLEASE LIST ANY HISTORY OF TRANSPLANTS OR MAJOR SURGERIES OR ILLNESSES

Surgery/Transplant/ Illness	Date of Surgery/Illness	Member Name	Provider Name and Phone Number

PLEASE CHECK ANY THAT APPLY. ARE YOU OR ANY OF YOUR DEPENDENTS:

b	Condition	Member Name	Provider Name and Phone Number
	Pregnant		
	Diabetic		
	Asthmatic		

Fax or Mail to: Fax - (402) 498-9706 • Attention: Health Services Department • Coventry Health Care of Nebraska, Inc. • 13305 Birch Street, Suite 100 • Omaha, Nebraska 68164

Completing this form does not guarantee continued payment of services. The amount of benefit coverage, if any, is subject to all plan provisions including the member's eligibility and any contractual limitations in effect when services are provided. All applicable co-payments, coinsurance and deductibles apply. Providers outside the network may require Coventry approval, based on your benefit plan design, and may be subject to your Out-of-Network rate.